HEDINGHAM MEDICAL CENTRE

PATIENT CONSENT FORM

(For transport and storage of medication to be collected from the Community Post Office at Great Yeldham READING ROOMS)

PATIENT'S DETAILS

Surname:			
First Names:			
Address:			
Date of Birth:		Gender	

THIS SECTION FOR COMPLETION BY THE PATIENT

1. I am the patient
2. I agree to the Community Post Office collecting my medication from the surgery and storing it at the Reading Rooms for me to collect
3. I agree to the Community Post Office returning my medication should I not collect it on the agreed day.
4. I understand that the Community Post Office will need to know my name, date of birth, gender and address for the purpose of identifying me and making sure that I collect the correct medications.

Signature:	
Date:	